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4. DRG Assignment

DRG values are determined using HCFA Grouper version 14.0. Each claim is assigned a DRG value that is the basis for categorizing claims into DRG groups.

5. Determination of DRGs paid within the DRG

A list of DRGs to be paid within the DRG portion of the system and a list to be paid within the CCR portion of the system is established using the following criteria:

a. Frequency of Cases

DRGs that have insufficient case volume to set a reliable DRG relative rate are assigned to the CCR portion of the hybrid system. The formula for determining the minimum number of cases is as follows:

$$N = \frac{(Z \times S)^2}{(R)}$$

where N = Minimum Sample Size
S = Standard Deviation
R = Error Level
Z = Confidence Level (90 %)

For any particular DRG, if the actual number of cases is greater than the minimum sample size, N, the DRG is paid on a per discharge basis.

b. High Variance

DRG categories with unusually high variation are paid on a CCR basis. High variation DRGs are defined as categories where a large percentage of the cases are widely scattered from the mean. This high variation creates an unreliable average per case amount.

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6. DRG Relative Weights

Relative weights are computed for the per discharge DRGs and are computed from Georgia claims data. For each DRG, the weight is calculated by taking the average operating cost per case and dividing it by the average operating cost per case across all DRG cases.

7. Hospital Case-Mix Index

This value is computed for each hospital that has cases falling within the per case DRG categories. The case-mix index is computed for each hospital by multiplying the number of cases for each per case DRG by the appropriate DRG relative weight. After this value is computed for each DRG and summed, this amount is then divided by the total number of per discharge DRG cases for the hospital. The resulting calculation is the case-mix index, which represents the average resource intensity of the per case DRG cases for a hospital.

8. Hospital Average Cost per Case

For each hospital, the average operating cost per case is calculated by summing the total operating costs for DRG cases and dividing by the total number of cases.

9. Peer Groups

Each hospital is assigned to one of the four peer groups (urban, rural, pediatric, or special care) according to:

a. The hospital's Medicare classification as either a facility in an MSA (urban) or not in an MSA (rural) or

b. An identifiable set of unique hospital attributes

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II. Payments for Non-Outlier Cases

A. Payment Formulas

Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + Capital Add-on + GME Add-on (if applicable)

Outlier DRG Payment Per Case = (Allowable Charges x Hospital Specific Operating Cost-to-Charge Ratio) + Capital Add-on + GME Add-on (if applicable)

B. Operating Payment

Under the Hybrid DRG System, all cases are reimbursed on a per case basis. Operating costs are reimbursed in one of two ways:

- Within the DRG portion of the system
- Within the CCR portion of the system

An additional, or add-on, payment for capital and direct medical education is described in Section II.B.3.

1. DRG Base Rates

For each case, the computation of the total DRG payment for non-outlier DRG cases is computed as follows. This section focuses on the calculation of the Base Rate payment component.

a. Case-Mix Adjusted Average Costs

Each hospital's average DRG non-outlier operating cost per case is divided by the hospital's case-mix index, resulting in an average cost per case without the effect of case-mix.

b. Peer Group Base Rates

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The case-mix adjusted total DRG inlier operating cost is calculated for each facility by multiplying the case-mix adjusted average cost for each hospital by the total number of DRG cases. The total case-mix adjusted cost is summed across hospitals for each peer group and divided by the number of cases within each peer group. The resulting value for each peer group is the peer group base rate. Each facility is assigned their appropriate base rate based upon the hospital's peer group classification.

c. Hospital-Specific Base Rates

Peer group Base Rates are adjusted according to the percentage of estimated DRG non-outlier operating payments above or below a hospital's average cost per case. For DRG cases, estimated losses will be prospectively limited to 90 percent of non-outlier operating costs and estimated gains prospectively limited to 110 percent of non-outlier operating costs.

d. Adjustment to Rural Hospital-Specific Base Rates

The hospital-specific base rates for hospitals in the rural peer group will be adjusted upwards by 3.3 percent. This adjustment reinstates the one percent that was removed from the inflation factors in Section I.B.3. The reason for a 3.3 percent increase was that when DMA modeled the DRG system, costs were inflated by a nationally standardized inflation rate minus one percent for every year. For example, if the inflation rate for the state fiscal year was 3.4 percent, costs were inflated by 2.4 percent. This is standard DMA practice since it was found that hospital costs in Georgia were growing at a slower pace than the national rate. The 3.3 percent increase reinstates the one percent reduction (compounded from the base year to the payment year).

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2. Cost-to-Charge Operating Payment

As specified in Section I.A.2 operating cost-to-charge ratios are computed from hospital cost reports. Any cost-to-charge ratio exceeding 1.0 is set to 1.0. These cost-to-charge ratios are used to determine reimbursement for cases that do not classify into one of the DRG reimbursement categories. The operating cost-to-charge ratio was calculated in the following manner.

a. Divide Medicaid Inpatient Charges from the cost report by the Total Patient Revenue from the cost report to obtain the Medicaid Charge-to-Revenue Ratio.

b. Subtract the Total CRNA Costs reported on the cost report from the Total CRNA Costs reported on the CRNA survey to obtain the CRNA Reduction.

c. Multiply the Medicaid Charge-to-Revenue Ratio by CRNA Reduction amount to obtain the Medicaid Portion of the CRNA Reduction.

d. Subtract the Medicaid Portion of the CRNA Reduction from the Medicaid Inpatient Costs from the cost report to obtain the Medicaid Inpatient Costs Adjusted for CRNA.

e. Divide Medicaid Inpatient Operating Costs Adjusted for CRNA by the Medicaid Inpatient Charges from the cost report to obtain the Cost-to-Charge Ratio.

3. Hospital Specific Add-on Payment

For both DRG and CCR cases, reimbursement for non-operating costs is made through a hospital-specific add-on payment. Add-on amounts include capital and applicable GME costs per discharge.

a. Capital cost per discharge represents all capital costs reported on the Medicare cost reports or collected by DMA through the capital surveys. The capital portion of the add-

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on is computed by dividing capital costs by the hospital cost report Medicaid discharges.

1. Divide the Medicaid Inpatient Costs from the cost report by the Total Costs from the Cost Report to obtain the Medicaid Allocation Ratio.

2. Sum the Total Buildings and Fixtures capital costs and the Total Major Movable capital costs from the cost report to obtain the Total Capital Costs.

3. Multiply the Medicaid Allocation Ratio by the Total Capital Costs to obtain the Medicaid Allocation of Capital Costs.

4. Divide the Medicaid Allocation of Capital Costs by the Medicaid Discharges to obtain the Cost Report Capital Cost Per Case.

5. Multiply the Total Capital Expenditures from the Capital Expenditure Survey by the Medicaid Allocation Ratio to obtain the Medicaid Allocation of Survey Capital Costs.

6. Divide the Medicaid Allocation of Survey Capital Costs by the Medicaid Discharges to obtain the Survey Capital Cost Per Case.

7. Sum the Cost Report Capital Cost Per Case and the Survey Capital Cost Per Case to obtain the Capital Add-on.

b. The GME add-on is calculated for the applicable hospitals in the following manner.

1. Multiply the Total Graduate Medical Education Costs from the cost report by the Medicaid

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Allocation Ratio to obtain the Medicaid Allocation of GME.

2. Divide the Medicaid Allocation of GME by the Medicaid Discharges to obtain the Medicaid GME per case.

3. Multiply the Medicaid GME per case by the DRI inflation factor (from the midpoint of the cost report year to the midpoint of the payment year) minus 1 to obtain the GME Add-on.

C. Coding Adjustment Factor

A two percent reduction in the hospital base-rate and cost-to-charge ratio is made to account for improvements in hospital coding practices resulting from the implementation of a prospective DRG system. The application of the adjustment to the base rate applies to the base-rate amount that is unaffected by the stop loss or stop gain adjustment described in Section II.B.1.c of this plan.

III. Payments for Outlier Cases

Special treatment is made for cases that have unusually high costs under the prospective payment system. For both DRG and CCR cases, special payment methods have been developed.

A. DRG Cases

DRG cases with operating costs meeting both of the following conditions will be considered for outlier reimbursement:

1. The operating costs exceed the DRG cost threshold for this DRG, where the threshold equals three standard deviations above the geometric mean cost for DRG cases.

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2. The operating costs exceed the overall cost threshold for all cases, where the threshold equals two standard deviations above the geometric mean costs for all cases (per discharge and percent of allowed charge).

The additional payment for DRG outlier cases equals the DRG payment amount plus 80 percent of costs above the DRG base payment amount. (the base-rate multiplied by the relative weight)

B. CCR Cases

CCR cases with operating costs meeting both of the following conditions will be considered for outlier reimbursement:

1. The operating costs exceed the MDC cost threshold for this DRG, where the threshold equals three standard deviations above the MDC geometric mean cost for DRG cases.

2. The operating costs exceed the overall cost threshold for all cases, where the threshold equals two standard deviations above the geometric mean costs for all cases (per discharge and percent of allowed charge).

Payment for CCR cases equals the MDC outlier operating cost threshold plus 80 percent of costs above the MDC outlier threshold.

IV. Special Payment Provisions

A. New Facilities

1. Payments for new facilities will be determined as follows:

a. Facilities under the DRG system will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified.

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b. Facilities under the DRG system will receive a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group.

2. New facilities will receive payments described in Sections II and III once a recalculation of the base year is performed by DMA for all facilities.

3. New facilities currently operating under the previous DMA three year cost settlement policy will continue to be cost settled until the end of their three year period.

B. Out-of-State Facilities

1. Inpatient prospective rates will be determined as follows:

a. Facilities under the DRG system will receive a hospital specific base rate that is equal to the statewide average rate for the peer group in which the hospital is classified.

b. Facilities under the DRG system will receive a capital add-on payment equal to the statewide average add-on payment.

2. Outlier Case

Payments for outlier cases will be calculated in the same manner as described in Section III except that the cost-to-charge ratio for all out-of-state facilities will be set at the Georgia statewide average of the cost-to-charge ratios.

C. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section IV.A.

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XVIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.